

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04727

4727

CERTIFICATE OF DEATH

Reg. Dist. No. 198

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> <u>Howard</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Ellicott City</u>		OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>90</u> <u>Highland Manor Nurs. Ho.</u>		<u>1034 E. North Ave.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH: <u>May 16 1955</u>	
<u>MATTIE (MAGGIE) L. CRADDOCK</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Jan. 15, 1867</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>88</u> yrs.		Months	Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>none</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Md.</u>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Joseph N. Craddock</u>		<u>Anna Hubbard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>9</u>			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Mrs. Mattie Craddock-1034 E. North Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>443X</u>			
IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Cardio-vascular disease</u>			
DUE TO <u>with Hypertension and Mal-nutrition</u>			
(B) <u>(Diagnosis obtained from</u>			
DUE TO <u>Dr. Elsworth Cook who had</u>			
(C) <u>attended her prior to</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Coming to Present Nursing Home</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 16, 1955</u> , to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>M. from the causes and on the date stated above.</u>			
SIGNATURE		DATE SIGNED	
<u>Gendert B. Taylor</u>		<u>May 17, 1955</u>	
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Buried</u>		<u>Loudon Park Cem.</u>	
DATE THE DEED		LOCATION (City, town or county) (State)	
<u>5/18/55</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		FUNERAL DIRECTOR	
<u>5-17-55</u>		<u>Dr. M. J. Pickner</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>and Hedberg</u>		<u>1034 E. North Ave.</u>	

WASHINGTON, D.C. 20462

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official letter.]

05671

Reg. Dist. _____

No. 193

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Woodbine</u>				TOWN <u>Woodbine</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Annapolis Rock Road</u>				STREET ADDRESS (If rural, give location) <u>Annapolis Rock Road</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Mortimer</u>		(Middle) <u>Dorsey</u>		(Last) <u>Duvall</u>		(Month) <u>May</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH: <u>9/28/1883</u>	
9. AGE last birthday: <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Woodbine, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <u>John Wesley Duvall</u>				14. MOTHER'S MAIDEN NAME: <u>Victoria Every</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No.: <u>213-32-3510</u>		17. INFORMANT & ADDRESS: <u>Benj. F. Duvall, Eccleston, Balto. Co. Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a)..... <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....				<u>Instant</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
<u>Woodbine</u>		<u>Howard</u>		<u>Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>George E. Bunting</u>		Ellicott City, Md.		M. D. <u>May 14, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>5/17/1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Jennings Chapel</u>	
LOCATION (City, town, or county) (State): <u>Florence, Howard Co., Md.</u>		24. FUNERAL DIRECTOR: <u>F.C. Higinbotham</u>		ADDRESS: <u>Ellicott City, Md.</u>	
DATE REC'D BY LOCAL REG. <u>5-3-1955</u>		REGISTRAR'S SIGNATURE: <u>C. Pearl</u>			

RECEIVED

JUL 1 1955

BUREAU V. 2

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter with several lines of text, mostly mirrored or bleed-through from the reverse side.]

MARYLAND

STATE DEPARTMENT OF HEALTH

4728

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>	
X TOWN <u>Cooksville</u>		OR TOWN <u>Cooksville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Sarah Jane Francis</u>		4. DATE OF DEATH <u>May 19 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 25, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year: Months Days If under 24 hrs: Hours Min.
11. FATHER'S NAME <u>George Berry</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Ella Dorsey</u>	
15. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Albert Francis - Cooksville, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
434.2 Immediate cause (a) <u>Cardiac Arrest - Cardiac failure</u>		<u>3 months</u>
Antecedent cause(s) (b) <u>arteriosclerosis, pulmonary disease -</u>		<u>Feb 55</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		<u>May 55</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>—</u>	19b. MAJOR FINDINGS OF OPERATION <u>—</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1955, to May, 1955, that I last saw the deceased alive on 19 May, 1955, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE Howard E Hall MD (Degree or title) ADDRESS Cooksville, Md DATE SIGNED 19 May 55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-22-55</u>	<u>Dorsey-Francis Family</u>	<u>Cooksville, Howard Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 21, 1955</u>	<u>E Paul Munn</u>	<u>Arthur H Haight</u>	<u>Cooksville, Md</u>

MARGIN RESERVED FOR BINDING

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MAY 31 1955

BUREAU V. S.

04729

MARYLAND

STATE DEPARTMENT OF HEALTH

4729

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>High Ridge, Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>High Ridge, Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Emma</u> (Middle) <u>Nelena</u> (Last) <u>Grimes</u>		(Month) <u>May</u> (Day) <u>2</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	9. AGE last birthday <u>57</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md</u>
13. FATHER'S NAME <u>James Redmond</u>	14. MOTHER'S MAIDEN NAME <u>Ella Mrs. Stecher</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	17. INFORMANT AND ADDRESS <u>Thomas C. Redmond Laurel Md</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>420.1 Acute Coronary Occlusion</u>		<u>5 min.</u>
(b) <u>Antecedent cause(s) Coronary Insufficiency</u>		<u>3 mo.</u>
(c) <u>II. OTHER SIGNIFICANT CONDITIONS</u>		
Conditions contributing to the death but not related to the disease or condition causing death. <u>Acute Viral Infection</u>		<u>3 wks.</u>
19a. DATE OF OPERATION <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE <u>NONE</u> (Specify)	PLACE (Home, farm, factory, street, OF office bldg) <u>NONE</u>	(CITY OR TOWN) <u>NONE</u> (COUNTY) <u>NONE</u> (STATE) <u>NONE</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>NONE</u>	INJURY OCCURRED While at <u>NONE</u> Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>NONE</u>

22. I hereby certify that I attended the deceased from 3/1, 1955, to 5/2, 1955, that I last saw the deceased alive on 4/26, 1955, and that death occurred at 2:05 P.m., from the causes and on the date stated above.

SIGNATURE J. M. Warren Md ADDRESS Laurel DATE SIGNED 5/2/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 4, 1955</u>	<u>St. John Cemetery</u>	<u>Highland, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 4 - 1955</u>	<u>Frank Shipley</u>	<u>De Witt Donaldson</u>	<u>Laurel Md</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 10 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **04730**
4730 CERTIFICATE OF DEATH

Reg. Dist. No. **191**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Howard		MARYLAND		STATE Oregon		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town) X TOWN Ellicott City		LENGTH OF STAY (in this place) 4 mos		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beaverton 74X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Taylor Manor Hospital				STREET ADDRESS (If rural give location) 10175 S. W. Old Orchard Lane			
3. NAME OF DECEASED: (First) (Middle) (Last) Elida S. Jilson				4. DATE (Month) (Day) (Year) OF DEATH May 8 19 55			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH: May 17, 1863	9. AGE last birthday 91 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Creston, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Charles Mellen				14. MOTHER'S MAIDEN NAME: Annis St. Johns			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Dr. C. L. Newberry 10175 Old Orchard Lane Beaverton, Oregon			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Senility						5 years	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic C.V. D.						8 years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from Jan. 12, 19 55 to May 7, 19 55 , that I last saw the deceased alive on May 7, 19 55 , and that death occurred at 7:45 P. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Dr. C. L. Newberry		Dr. C. L. Newberry		May 8, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 5/11/55		NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		LOCATION (City, town, or county) (State) Rockford, Illinois	
DATE REC'D BY LOCAL REGISTRAR May 9, 1955		REGISTRAR'S SIGNATURE John B. Loughman		24. FUNERAL DIRECTOR Easton Sons		ADDRESS Catonsville, Md.	

BUREAU V. S.

MAY 13 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04731

4731

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS ELlicott City		STREET ADDRESS (If rural, give location) Old Montgomery Rd, Ellicott City	
3. NAME OF DECEASED (Type or Print)	John Benson Lewis	4. DATE OF DEATH	May 7 1955
5. SEX	male	6. COLOR OR RACE	white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	single	8. DATE OF BIRTH	9/20/53
9. AGE last birthday	1 yrs.	10. KIND OF BUSINESS OR INDUSTRY	none
11. BIRTHPLACE (State or foreign country)	Bethesda, Md.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	John Fulton Lewis	14. MOTHER'S MAIDEN NAME	Mary Benson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	no	16. SOCIAL SECURITY No.	none
17. INFORMANT AND ADDRESS	William Mahoney, 3306 N. Hilton St., Balto.		
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
475X Immediate cause		(a) LARYNGOSPASM, POSSIBLE REFLEX CARDIAC ARREST	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) ACUTE TRACHEITIS	
(c) UPPER RESPIRATORY INFECTION		1 week	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none significant			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-28, 1955, to 5-7, 1955, that I last saw the deceased alive on 5-2-55, and that death occurred at 4:20 A.M., from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Donald E. Fisher		5-7-55	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	5/9/55	Christ Church Cemetery	Guilford, Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5-7-55	Mark Shipley	F.C. Higinbotham	Ellicott City, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 16 1955

BUREAU V. S.

4732
CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNSTREET
ADDRESS (If rural give location)3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
yrs Months Days Hours Min.10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

480X
Immediate cause

(a) Post-influenzal Broncho-Pneumonia - 2 weeks

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b) Chr. Myocarditis

Interval Between
Onset And Death

1 yr.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m.INJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1954 to May 2, 1955, that I last saw the deceased
alive on May 5, 1955, and that death occurred at 11:30 AM, from the causes and on the date stated above.
SIGNATURE Frank Shipley M.D. ADDRESS 547/55 DATE SIGNED 5/4/5523. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

MAY 9 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4733

CERTIFICATE OF DEATH

 04733
 Reg. Dist. No. 920

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ellicott City</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>				STREET ADDRESS (If rural give location) <u>6317 Wallis Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Louis G. Rosenheim Sr.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 16 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept 3, 1873</u>	9. AGE last birthday: <u>81 yrs.</u>	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>retired Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Wholesale Furniture</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Gustav</u>				14. MOTHER'S MAIDEN NAME: <u>Betsy Frank</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Estelle Rosenheim-6317 Wallis Ave.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>						15 mon.	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardio vascular disease</u>						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>						2 years	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from <u>May 14, 1955</u> to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>7:30 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>Irving J. Taylor</u>				M.D. <u>Taylor Manor Hospital</u> <u>May 16, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-17-55</u>		REGISTRAR'S SIGNATURE <u>aw [signature]</u>		24. FUNERAL DIRECTOR <u>Stm. G. Pickner & Sons</u>		ADDRESS <u>Balto 17 md</u>	

RECEIVED BY THE DEPARTMENT OF THE INTERIOR

1900

TO THE SECRETARY OF THE INTERIOR
FROM THE COMMISSIONER OF THE GENERAL LAND OFFICE
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

RECEIVED BY THE DEPARTMENT OF THE INTERIOR
FROM THE COMMISSIONER OF THE GENERAL LAND OFFICE
SUBJECT: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04734
4734 CERTIFICATE OF DEATH Reg. Dist. No. 19/

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard	MARYLAND	STATE W. Va.	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town) X TOWN Ellicott City	LENGTH OF STAY (in this place) 3 weeks	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Charles Town 85x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Taylor Manor Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Charles	(Middle) H.	(Last) Strider, Sr.	OF DEATH: May 25 19 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Apr 10, 1892
9. AGE last birthday: 63 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Live stock farmer		10B. KIND OF BUSINESS OR INDUSTRY: Farming	
11. BIRTHPLACE (State or foreign country): Jefferson Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Nicholas S.S. Strider		14. MOTHER'S MAIDEN NAME: Emma Talbott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): No		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT & ADDRESS: Charles H. Strider Jr.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis DUE TO			5 min.
ANTECEDENT CAUSE (S) (B) Arteriosclerotic cardio vascular disease yrs ? DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Depression			3 mos
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY atreet, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from May 5, 1955 to May 25, 1955 that I last saw the deceased alive on May 25, 1955, and that death occurred at 11:15 AM, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: May 28, 1955	
NAME OF CEMETERY OR CREMATORY: Edge Hill		LOCATION (City, town, or county): Charles Town, W. Va.	
24. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REGISTRAR: 5-27-55		REGISTRAR'S SIGNATURE: John B. Loughran	
24. FUNERAL DIRECTOR: C. H. Loughran		ADDRESS: Ellicott City Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

BUREAU V. 31

JUN 1 1955

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

4735

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fulton		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fulton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) ARTHUR W. WESSEL		4. DATE OF DEATH (Month) MAY (Day) 23 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH 12-18-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	9. AGE last birthday 73 yrs.
11. BIRTHPLACE (State or foreign country) Fulton, Md		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Herman F. Wessel		14. MOTHER'S MAIDEN NAME Catherine D. Hines	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Albert Wessel, Fulton, Md			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) Coronary Thrombosis			1 wk.
Antecedent cause(s) (b) Diabetes Mellitus			4 yrs.
(260x) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertensive C.-V. Disease			10 yrs.
Cerebral Hemorrhage			1 yr.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/12 , 19 52 , to 5/23 , 19 55 , that I last saw the deceased alive on 5/23 , 19 55 , and that death occurred at m. from the causes and on the date stated above.			
SIGNATURE J. M. Warren M.D.		ADDRESS Laurel Md	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 5-26-55	
NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran		LOCATION (City, town, or county) Fulton, Md	
DATE REC'D BY LOCAL REG. 5-27-55		REGISTRAR'S SIGNATURE Marie G. Whitaker	
24. FUNERAL DIRECTOR F.C. Higinbotham		ADDRESS Ellicott City, Md	

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BUREAU V. S.

JUN 3 1955

RECEIVED

05677

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

1. PLACE OF DEATH:

COUNTY Howard

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN Ellicott CityLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS81 Columbia Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Howard

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN Ellicott CitySTREET
ADDRESS

(If rural, give location)

81 Columbia Road3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Margaret Beavers Campbell White4. DATE
OF
DEATH

(Month) (Day) (Year)

5-31-55

19

5. SEX:

Female6. COLOR OR
RACE:White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Married

8. DATE OF BIRTH:

9-28-1912

9. AGE last birthday:

42

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired) At Home10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Colorado12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)No

16. SOCIAL SECURITY No.:

212-20-7084

17. INFORMANT & ADDRESS:

Elmer White, Ellicott City, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

Coronary thrombosis

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b).....

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
InstantII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY21e. INJURY OCCURRED
While at Not while
work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and
find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

Ellicott City, Md

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAM.

DATE SIGNED

6-1-195523. BURIAL, CREMATION,
REMOVAL (Specify):Burial

DATE THEREOF

6-4-55

NAME OF CEMETERY OR CREMATORY

Good Shepherd

LOCATION (City, town, or county)

Ellicott City, Md

(State)

DATE REC'D BY LOCAL
REG. 6-3-55

REGISTRAR'S SIGNATURE

John B. Laughan

24. FUNERAL DIRECTOR

F.C. Higinbotham, Ellicott City, Md

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUN 13 1955

RECEIVED